

There's a better way to fight the next pandemic. Here's how Singapore can help

From facilitating vaccine approval to contributing to ASEAN's response, there's much that can be done to prepare for when Disease X strikes.

Teo Yik Ying

It has been just over three years since the World Health Organization (WHO) declared the end of Covid-19 as a global health emergency. But for those preparing for the next health crisis, the work has never stopped.

Singapore's Health Minister Ong Ye Kung recently described Disease X, the as-yet unidentified pathogen capable of causing the next pandemic, as an "evolutionary certainty".

The question that looms large is whether we will be better prepared next time than we were for Covid-19. Have we learnt the right lessons from that crisis even as we face new challenges posed by pathogens as well as politics?

For instance, vaccine approval and production formed a major challenge during the Covid-19 outbreak as the world had to deal with a novel pathogen. Singapore could help by speeding up the vaccine approval process, the minister suggested in his comments, ahead of a United Nations meeting on pandemics in September.

The Health Sciences Authority could step up to ease the workload of existing regulatory authorities, he said, so that "we don't need WHO to do all the work itself". Singapore's offer comes at a time when it is building capabilities to develop and manufacture mRNA vaccines, while strengthening genomic surveillance and partnerships for vaccine development.

Behind these initiatives lies a much bigger question: How should the world organise itself differently before the next health crisis arrives? At a regional level, can South-east Asia do better with the resources it has?

Covid-19 showed why the answer matters. At precisely the moment when every government was responsible for protecting its own population, many poorer countries discovered how little control they had over some of the things that mattered most.

Vaccines were manufactured elsewhere. Supply contracts were negotiated elsewhere. Export decisions were taken elsewhere. Donations arrived according to other countries' timelines and sometimes with little time remaining before doses expired.

Decisions made thousands of kilometres away could determine whether a health minister could protect the population for which he or she was responsible.

A NEW GLOBAL HEALTH ARCHITECTURE

It is against this backdrop that Ghana's President John Dramani Mahama launched a push for changes to global health architecture and governance in September at the UN.

The campaign's central proposition – as outlined in its Accra Reset Initiative report – is deceptively simple: Countries should have the ability to decide what matters most for the health of their own people, and the capability to act on those decisions.

It envisages countries building sufficient capability to protect their own populations; regions sharing capabilities that make little sense for every country to duplicate; and global institutions concentrating on threats and functions that genuinely require global cooperation.

Fundamentally, it seeks to change the relationship between countries and the global health



Singapore's strength lies in bringing people together, building institutions that work, following through on commitments and holding ourselves accountable for the results, says the writer. PHOTO: AFP

system: from dependency towards sovereignty; from donor priorities towards country-led priorities; and from assistance towards partnership.

While the initiative began in Africa, its ideas are equally relevant to South-east Asia.

MAKING BETTER USE OF SOUTH-EAST ASIA'S RESOURCES

For instance, no South-east Asian country needs to possess every capability required to confront the next pandemic. But every government needs sufficient capacity to detect threats, make decisions and protect its population. Highly specialised capabilities can then be shared regionally, while WHO and other international institutions perform functions that genuinely require global coordination.

Unlike parts of Africa, almost every South-east Asian economy is now at least middle-income. Poverty, inequality and weaknesses in health systems remain, but the region collectively possesses considerable financial resources, technical expertise, manufacturing capacity and human capital.

Health sovereignty is therefore not an abstract aspiration. Much of the capability already exists; the challenge is to organise and share it better.

At the national level, financial sovereignty begins with making better use of existing health budgets. Countries need stronger health technology assessment, priority-setting, programme evaluation and strategic purchasing, while reducing waste from inefficient procurement and fragmented programmes.

They must also invest in the less visible infrastructure of sovereignty: reliable health data and the people capable of turning evidence into policy. This means building up the ranks of not only doctors and nurses, but also regulators, epidemiologists, health economists, behavioural scientists, biostatisticians, public health lawyers and policy evaluators.

But South-east Asia should not need every country to build every capability independently.

Regulation is an obvious example. ASEAN already has a Joint Assessment Procedure allowing regulators to evaluate medicine together while the national authorities retain the final decision. This could evolve into deeper joint assessment and regulatory reliance.

Singapore and Indonesia are well positioned to lead. Both have regulatory authorities recognised by WHO as WHO-Listed Authorities. Their expertise could anchor joint reviews and training across ASEAN, allowing countries with smaller agencies to draw upon regional expertise rather than duplicate highly specialised capabilities domestically.

In dealing with the next pandemic, this could mean that instead of every ASEAN regulator separately reviewing the same vaccine from scratch, trusted regulators share assessments and expertise, allowing safe and effective products to reach populations more quickly while national authorities retain sovereignty over final decisions.

The same logic applies to procurement. Thailand already plays a leading role in ASEAN vaccine security and could work with Indonesia and other major markets on pooled procurement for selected vaccines, antibiotics and essential medicine.

Aggregating demand across a region of almost 700 million people would strengthen South-east Asia's negotiating power while giving manufacturers greater certainty of demand. Smaller markets such as Brunei, Laos, Cambodia and Timor-Leste could benefit particularly.

Singapore too stands to gain as its small population makes procurement of specialised products such as medicine for rare diseases commercially challenging.

Health sovereignty does not mean that everything has to be manufactured domestically. Indonesia and Thailand, with existing pharmaceutical and vaccine capabilities, can serve as important regional production bases, complemented by growing capabilities in Malaysia and Vietnam, and Singapore's biomedical research and advanced manufacturing ecosystem.

What matters is not where every product is manufactured, but whether ASEAN can reliably obtain essential products when they are needed.

Health security can also be strengthened via a regional approach. Existing initiatives such as the Asia Pathogen Genomics Initiative, Singapore's Asia Centre for Health Security and ASEAN's emerging regional health security architecture could be connected into a stronger system for epidemic intelligence, genomic surveillance, information sharing and outbreak response.

Finally, expertise itself should become a regional public good. ASEAN could establish a mechanism allowing government to rapidly draw upon technical experts from across South-east Asia, supported by regional financiers such as the Asian Development Bank.

WHAT SINGAPORE CAN OFFER

Singapore occupies an unusual position in this emerging architecture. Economically and institutionally, it shares many characteristics of the Global North. Geographically, historically and strategically, it is embedded in South-east Asia and the Global South. Rather than see this ambiguity as a problem, Singapore can treat it as an asset.

with measures such as Nutri-Grade, the Agency for Care Effectiveness' expertise in health technology assessment and value-based pricing, the Communicable Diseases Agency's infectious disease capabilities, and the National Environment Agency's experience with Project Wolbachia are repositories of policy knowledge.

Singapore should not export these policies as templates to be copied, for that would reproduce the very paternalism that hobbled the pandemic response. Instead, it can make the evidence, implementation lessons, policy frameworks and technical expertise behind them accessible to neighbouring countries to adapt to their circumstances.

There is also a role for Singapore's growing philanthropic ecosystem.

Temasek Trust and the Philanthropy Asia Alliance sit amid an expanding community of foundations, family offices and philanthropists seeking to contribute to social progress in Asia.

But good intentions do not automatically produce good systems. If every donor funds a favourite disease, pilot project or community, the result can be a constellation of worthwhile projects that never adds up to a functioning health system.

Fragmented philanthropy can also burden governments with multiple reporting requirements.

Philanthropy can instead finance what governments and commercial investors often find difficult to fund: regional surveillance, regulatory strengthening, health economic evaluation and stronger local universities.

After all, the ultimate success of technical assistance should be to make repeated technical assistance unnecessary.

Universities have a similar responsibility.

Political administrations change, whereas building a sound health system requires decades of strategic investments.

Academia can help governments maintain long-term perspectives that survive electoral cycles, provide technical expertise and independent evaluation, and build the pipeline of people on which sovereignty ultimately depends.

Singapore's universities should

therefore ask whether their ambition is simply to train more international students here, or also to strengthen universities elsewhere so countries can eventually train their own experts at home.

The latter may be less visible than another overseas programme carrying a Singapore brand, but it could be far more transformative.

THE ASEAN OPPORTUNITY

The Accra Reset Initiative on global health reform as championed by the Ghanaian President is sometimes described as a response to declining development assistance. That understates what is happening.

The old question in global health was: How can wealthy countries help poorer countries?

The emerging question is: What capabilities should every country possess, what should neighbouring countries do together, and what must the world still do collectively?

Singapore cannot finance the world's health needs, nor should it try to construct another global health bureaucracy. Our comparative advantage lies elsewhere: bringing governments, financiers, philanthropists, academics and technical agencies around the same table; translating ideas into institutions; and ensuring commitments are followed by implementation and measurement.

Our ASEAN chairmanship in 2027 provides an opportunity to put some of these ideas into practice.

Singapore's strength has never been its ability to outspend larger countries. It lies in bringing people together, building institutions that work, following through on commitments and holding ourselves accountable for the results.

These are precisely the strengths a more sovereign global health architecture will need to prepare for Disease X, and exactly where Singapore has something meaningful to offer.

• Teo Yik Ying is vice-president for global health and dean of the Saw Swee Hock School of Public Health at the National University of Singapore. He is also a member of the Accra Reset High-Level Panel on Reform of the Global Health Architecture and Governance.